SECOND CARNEGIE INQUIRY INTO POVERTY AND DEVELOPMENT IN SOUTHERN AFRICA

Reviewing the Health Centre policy
The Khala experience

by
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Carnegie Conference Paper No. 195

Cape Town 13 – 19 April 1984
Gazankulu is one of South Africa's so-called "black states". The Mhala district is an isolated island midway between Nelspruit and Iqwaleni. It is typical bushveld with limited water and poor agricultural potential. 152,000 people live in Mhala's 57 villages which vary in size and infrastructure. Health services are underdeveloped and comprise one 250-bed hospital (Tintswalo), one health centre, ten clinics and a mobile clinic.

Why did Wits Medical School become involved here? It was by both design and fate. At Wits we had people interested in rural health and a benefactor (Anglo American Chairman's Fund) prepared to sponsor rural health work. The government has encouraged the various medical schools to become involved in rural health care and has designated schools to particular "homelands".

So we became involved in Gazankulu and the Health Services Development Unit (HSDU), a project of the Wits Department of Community Health, was established. The objectives of the Unit are the training of appropriate health service staff, the expansion and development of clinic services and the creation of a health service which is community supportive and responsive to local needs. To succeed we need the goodwill, support and respect of the community and the wholesale backing of the existing health service.

This paper and the others of the HSDU are reflections, analyses, recommendations and ideas and are the product of our first two years' experience. Opinions expressed are based on the critical analysis of hard data on the one hand and on personal impressions on the other. Whatever the opinion, it has been acquired by first hand and sustained personal experience.

The papers cover three aspects of our experience:

1. The State of Health and Health Care in Mhala
   a. Health and Health Care in Mhala : an overview.
   b. The Nutritional Status of Children 1 - 5 years.

2. A Critique of Some Health Service Interventions in Mhala
   a. Community Health Workers in Mhala : Perversion of a Progressive Concept?
   b. How well do our Rural Clinics Function?
   c. Reviewing the Health Centre Policy.
   d. Mobile Clinics : What can and do they Achieve?

3. Health Service Interventions by the Wits HSDU
   a. Do Primary Health Care Nurses in Gazankulu provide Second Class Cheap Care to the Poor?
   b. Can good Tuberculosis Services be provided in the Face of Poverty?
   c. School Health Services : Problems and Prospects.
   d. Mass Immunization Campaigns - The Tintswalo Experience.

The message is that:
- Health care in Mhala is inadequate.
- This care can be improved without preceding changes in the present economic and political systems.
- Such improvement is limited by social, economic and political constraints which are the root cause of such illness.
- It is worth working in "homeland" health services because of what can be achieved.

In acknowledging all who have worked in or with HSDU it must be remembered that health service development is a team effort. Many of the people of Mhala, the hospital staff, primarily Dave Stephenson as superintendent and the community health nurses, Dr Erica Suter and the superintendents and staff of Gazankulu's other hospitals, the health department led by Dr Moos and, more recently, Dr Robert, and the Chief Minister of Gazankulu have all contributed to the establishment and development of the Unit. The Chairman's Fund of Anglo American and the University of the Witwatersrand have provided the infrastructure.

The action has come from Anita and Rob Backentose, Eric Buch, Rob Collins, Cedric de Beer, Clive Evian, Vic Gerecke, Merryl Hammond, Thoko Maluleke, Shirley Maswanganyi, Sunilelswe Mtetwa, Dipuo Mosowe, Robert Vaugh and Merrick Zweinstein.

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MARCH 1984
REVIEWING THE HEALTH CENTRE POLICY : THE MHALA EXPERIENCE

Eric Buch & David Stephenson

A health centre is a health facility between a large clinic and a small hospital. It has a staff of 20 - 40, including 5 - 10 registered nurses. The health centre should serve a population of more than 100 000. In rural areas it delivers routine clinic care, but may provide more sophisticated care and have some beds for short stay patients. According to the health facilities plan, health centres are a key component in the delivery of health care. (1)

The Gazankulu five year health plan of 1977 envisaged that health centres would replace clinics as the main community health care facility. (2) Twenty health centres would be built over the next five years. Five were planned for the Mhala district.

WHY DID GAZANKULU EMBARK ON A HEALTH CENTRE POLICY?

The reasons for introducing health centres were given in the five year plan. (2) These were to:

a. Ensure adequate staffing (by registered nurses)*
b. Provide a 24 hour service.
c. Have radio contact with the base hospital.
d. Have an ambulance (service based) at the health centre.
e. Provide limited inpatient care (for less severe acute diseases).
f. Provide accommodation for waiting mothers.

WHAT ARE THE PLANNED FEATURES OF HEALTH CENTRES IN GAZANKULU?

The health centre was planned as follows (2):

a. A capital cost of R30 000.
b. A staff of 40 including 8 registered nurses, 7 staff nurses and 6 nursing assistants. The other posts were for clerical, cleaning, driving, and security staff. Accommodation was to be provided for the nursing staff.
c. Inpatient facilities for 14 general and 6 maternity patients.

*( ) added by the authors
2.

d. A mobile clinic based at the health centre.

e. It would replace clinics, although a few might continue in "specific instances".

WHAT HAS HAPPENED IN PRACTICE?

To review the health centre policy we need to look at four areas:

a. The number of health centres that have been built.
b. The cost-benefit of services delivered by health centres.
c. Whether the reasons given for embarking on the health centre policy have proven themselves to be valid.
d. Whether the planned features have materialised.

How many health centres have been built?

Mphambo health centre, in another district of Gazankulu was the only one completed within five years. Only one of the five health centres envisaged for Nhala has been built. It opened at Agincourt in August 1982.

The main barrier to building more health centres has been the shortage of funds. As this paper develops it will be argued that a health centre does not justify its enormous cost.

Are the services of the health centre cost-beneficial?

The capital cost of the Agincourt health centre was over R400 000 - 14 times more than the R30 000 estimate. The health centre has cost about 8 times as much as a clinic to build and run. It should therefore undertake about 8 times as many health care tasks. Table I shows that Agincourt health centre provided less care than the average for our ten clinics in all categories except for deliveries.
TABLE I
COMPARISON OF PATIENTS CARED FOR AT AGINCOURT HEALTH CENTRE
WITH THE CLINICS IN MHALA IN 1983

<table>
<thead>
<tr>
<th></th>
<th>Average Patients per clinic</th>
<th>Patients at the Health Centre</th>
<th>% difference</th>
<th>Number of clinics with a greater work load</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ill patients</td>
<td>5978</td>
<td>4604</td>
<td>-23.0%</td>
<td>7</td>
</tr>
<tr>
<td>Antenatal Care</td>
<td>2042</td>
<td>1202</td>
<td>-41.1%</td>
<td>9</td>
</tr>
<tr>
<td>Child Health</td>
<td>5243</td>
<td>4876</td>
<td>-7.0%</td>
<td>7</td>
</tr>
<tr>
<td>Family Planning</td>
<td>668</td>
<td>579</td>
<td>-13.3%</td>
<td>6</td>
</tr>
<tr>
<td>Deliveries</td>
<td>47</td>
<td>128</td>
<td>+172.3%</td>
<td>0</td>
</tr>
</tbody>
</table>

Why has the health centre delivered less, rather than 8 times more care? The main reason is that the population density requirement of more than 100,000 people living within five kilometres of the health centre is not met. Transport is limited, and expensive in terms of what people can afford. In fact, Agincourt has similar population densities and transport facilities to the rest of Mhala.

Another factor causing low patient turnout is that health centre care costs R3.00, versus R2.00 at a clinic. Patients realise that the same care for an extra rand is not worth it.

Are the reasons for having health centres justified?

The six reasons given in the Gazankulu five year plan for embarking on the health centre policy were outlined earlier. If the health centres do not justify their existence on a cost benefit basis, can they justify them on these reasons. Let us look at each in turn.
4.

a. To ensure adequate staffing.

It is difficult to staff rural clinics with registered nurses. As their isolation in the clinics was thought to be the problem, having a group working together at a health centre was seen as the solution. This misses the point, as the key problem is not isolation; but inadequate training and support, and poor work conditions.

Only one of the 17 registered and staff nurse posts is filled.

b. To provide a 24 hour service.

A 24 hour service as close as possible to people is needed to avoid the high costs of transport at night. However, one does not need a health centre and 8 registered nurses to provide 24 hour emergency care. As the nightwork load is low (the health centre sees few patients at night), the needs of the community could be better met if each clinic had 2 registered nurses alternating call. This would reduce transport costs even more.

c. To have radio contact with the base hospital.

Radio contact is now available at clinics as well.

d. To have an ambulance service based at the health centre.

As nobody mans the health centre radio after hours, the ambulance only provides an 8 hour service to the surrounding clinics. If it were hospital based it would provide a 24 hour service and spend less time parked in the garage.

e. To provide limited inpatient care.

It would be a major advantage to patients if they could be admitted to a place nearer their home. But any patient who is ill enough to need admission should be seen by a doctor. For this the patient needs to go to hospital.

In any case, 12 beds is too few to have any real impact.
f. To provide accommodation for waiting mothers.

Accommodation for waiting mothers is a valuable service, but there is no advantage to it being at the health centre rather than at a clinic. If facilities were available at each clinic, mothers could wait nearer their homes and deliver at the clinic where they had received their antenatal care.

Have the planned features of the health centre materialised?

a. Cost.

The estimated capital cost of the health centre was R30 000. This has now spiralled to more than R400 000.

b. Staffing and staff accommodation.

Only one of the 15 registered and staff nurse posts have been filled. But, as all clerical, cleaning, security, and driver posts are full; our health centre has 19 administrative staff. Their clinic counterpart is 1 cleaner. The health centre has failed to recruit the required number of nurses and has added unnecessarily high administrative staff expenses.

Adequate accommodation for staff is not specific to a health centre. It can be provided as easily at a clinic.

c. Inpatient care.

It has already been pointed out that the value of this component of the service is questionable. At present it is being used as a staff residence [their accommodation has not yet been built].

d. A base for the mobile clinic.

There is no reason why a mobile clinic team must be based at a health centre. The vehicle could be based at any public facility (such as a clinic or malaria camp) near the worker's homes.
6. Replacement of clinics by health centres.

Health centres were planned to replace clinics. We believe that the information presented in this paper indicates that it would be an error to do this. One of the key features of the primary health care approach is the decentralisation of health services.

Health centres in rural areas oppose this by recentralising services at great cost to the health service and the community.

IS THERE A ROLE FOR HEALTH CENTRES IN RURAL AREAS?

Health centres probably have an important role to play in the provision of urban health care. They might be appropriate in rural areas where there is a large (over 100,000) population in the immediate vicinity of the health centre. This may occur in some of the so-called "closer settlements". They might also be worthwhile if health centres were upgraded to include doctors on their staff, and to have simple X-ray, laboratory, and theatre facilities available. This would then decentralise hospital services, rather than the current practice of using them to recentralise clinics. However, with so few doctors working in rural areas, the chances of allocating one full time to a health centre are slim.

In fact, building health centres before there are adequate clinics is placing the cart before the horse. The first phase of health care provision should be aimed at ensuring primary health care within 5km of every household. This could later be followed by the upgrading of some clinics to health centres, if the health service is able to match the requirements of more sophisticated care, and if the population density required is present.

CONCLUSION

The health centre policy was planned to improve the delivery of health care. We believe that the information we have presented proves that this is not true. We could have built and run 8 more clinics at the same cost as our 1 health centre.

It is crucial that health planners should carefully consider the likely flaws in apparently progressive innovations in order to avoid costly mistakes.
REFERENCES:


These papers constitute the preliminary findings of the Second Carnegie Inquiry into Poverty and Development in Southern Africa, and were prepared for presentation at a Conference at the University of Cape Town from 13-19 April, 1984.

The Second Carnegie Inquiry into Poverty and Development in Southern Africa was launched in April 1982, and is scheduled to run until June 1985.

Quoting (in context) from these preliminary papers with due acknowledgement is of course allowed, but for permission to reprint any material, or for further information about the Inquiry, please write to:

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